

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|----------------------------------|---|---|--------------------------------------|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 08940 | | | | | 08930 | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MECHANICSVILLE | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MECHANICSVILLE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First KATHARINE Middle CLAY Last ADAMS | | | 4. DATE OF DEATH Month JUNE Day 3 Year 19 66 | | | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/16/1870 | | 9. AGE (in years last birthday) 95 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 1 Hours 18 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME HENRY C. ADAMS | | | | | 14. MOTHER'S MAIDEN NAME ALICE O. BRAWNER | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO. 220 44 9541 | | 17. INFORMANT MRS. ALICE M. OSTERHOUT - MECHANICSVILLE, MD. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from July, 1955 , to June 3, 1966 , that (I) (we) last saw the deceased alive on June 2, 1966 , and that death occurred at 6 AM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Leon W. Berube | | | | | 22b. DATE SIGNED 6/4/66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) LEON W. BERUBE M.D. | | | | | 22d. ADDRESS MECHANICSVILLE, MD. | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF 6/6/66 | | 23c. NAME OF CEMETERY OR CREMATORY ALL FAITH CEMETERY | | 23d. LOCATION (City, town or county) (State) CHARLOTTE HALL, MD. | | |
| 24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MD. | | | | | 25a. REC'D BY REGISTRAR JUN 7 1966 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

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James E. Thompson

JUN 7 1966

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08941
CERTIFICATE OF DEATH
08931

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN ID 6 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL PINEY POINT d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOSEPH Middle REGINAL Last BLACKWELL | | 4. DATE OF DEATH Month JUNE Day 24 Year 1966 | |
| 5. SEX MALE 6. COLOR OR RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 19, 1966 9. AGE (In years last birthday) 6 yrs. IF UNDER 1 YEAR: Months 6 Days 6 Hours 6 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH G. CLARKE | | 14. MOTHER'S MAIDEN NAME EVANGALINE BLACKWELL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MOTHER | | Address SAME AS # 2 ABOVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 7545 DUE TO (b) Congestive Heart Failure DUE TO (c) Congenital Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH hrs hrs days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/19, 1966 to 6/24, 1966 that (I) was last saw the deceased alive on 6/24, 1966 and that death occurred at 6 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE James P. Jarboe | | 22b. DATE SIGNED 6/26/66 | |
| 22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M.D. | | 22d. ADDRESS GREAT MILLS, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 26, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY | | 23d. LOCATION (City, town or county) (State) ST. GEORGE ISLAND, MD | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR Charles Judge | |
| ADDRESS LEONARDTOWN, MARYLAND | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE JUN 29 1966 | | | |

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08942

08932

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - CALIFORNIA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARYS HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL ZELLAS BLOOM | | | | 4. DATE OF DEATH Month Day Year JUNE 18 1966 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 18, 1897 | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER - RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY RAILROAD | | 11. BIRTHPLACE (State or foreign country) PENNA. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JAMES BLOOM | | | | 14. MOTHER'S MAIDEN NAME EMMA WOLFORD | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 705 09 2415 | | 17. INFORMANT Address MRS. DOROTHY JENKINS - SAME AS #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH immediate |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE P.J. BEAN | | M.D. P.J. BEAN | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 6/19/66 | |
| EXAMINER'S NAME (Type) P.J. BEAN M.D. | | Address (Street, city, town, or county) GREAT MILLS, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 6/21/66 | | 23c. NAME OF CEMETERY OR CREMATORY GREENHILL CEMETERY | | 23d. LOCATION (City, town or county) (State) BERRYVILLE, VIRGINIA | |
| 24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN | | | | 25a. REC'D BY REGISTRAR JUN 21 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. The first part of the report is a general statement of the work done during the year. It includes a summary of the results of the various projects and a statement of the progress made in each of them. It also includes a statement of the financial position of the organization and a statement of the personnel who have been employed during the year.

2. The second part of the report is a detailed account of the work done during the year. It includes a description of the various projects and a statement of the results of each of them. It also includes a statement of the progress made in each of them and a statement of the financial position of the organization.

3. The third part of the report is a statement of the progress made in each of the various projects. It includes a statement of the progress made in each of them and a statement of the financial position of the organization.

4. The fourth part of the report is a statement of the financial position of the organization. It includes a statement of the financial position of the organization and a statement of the personnel who have been employed during the year.

5. The fifth part of the report is a statement of the personnel who have been employed during the year. It includes a statement of the personnel who have been employed during the year and a statement of the financial position of the organization.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHARLOTTE HALL | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL | | | | | | d. STREET ADDRESS Rt 1 Box 70 | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ABRAHAM Middle BUTLER Last BUTLER | | | | | | 4. DATE OF DEATH Month JUNE Day 11 Year 1966 | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE NEGRO | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH OCT. 21, 1882 | | 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 10 Hours 12 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER | | | | 10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOHN FRANCIS BUTLER | | | | | | 14. MOTHER'S MAIDEN NAME LOUISA ? | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT FLORINE BUTLER SAME AS # 2 ABOVE | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4221 DUE TO (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 126 1041 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to June , 19 66 , that (I) (we) last saw the deceased alive on 6/11/66 19 66 , and that death occurred at 4P M, from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE Leon W. Berube | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED JUN 15 1966 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) LEON W. BERUBE M. D. | | | | | | 22d. ADDRESS MECHANICSVILLE, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 15 1966 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPHS CEMETERY | | 23d. LOCATION (City, town or county) (State) M. ROANZA, MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR JUN 15 1966 | | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

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발행인: 김기현 (대표이사)

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DATE: 01/11/2001

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90 JOURNAL OF DOCUMENTATION

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CHEN, J. Q. AND J. L. WILSON

U. S. DEPARTMENT OF AGRICULTURE

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

234

W. F. SAGE, ATTORNEY AT LAW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

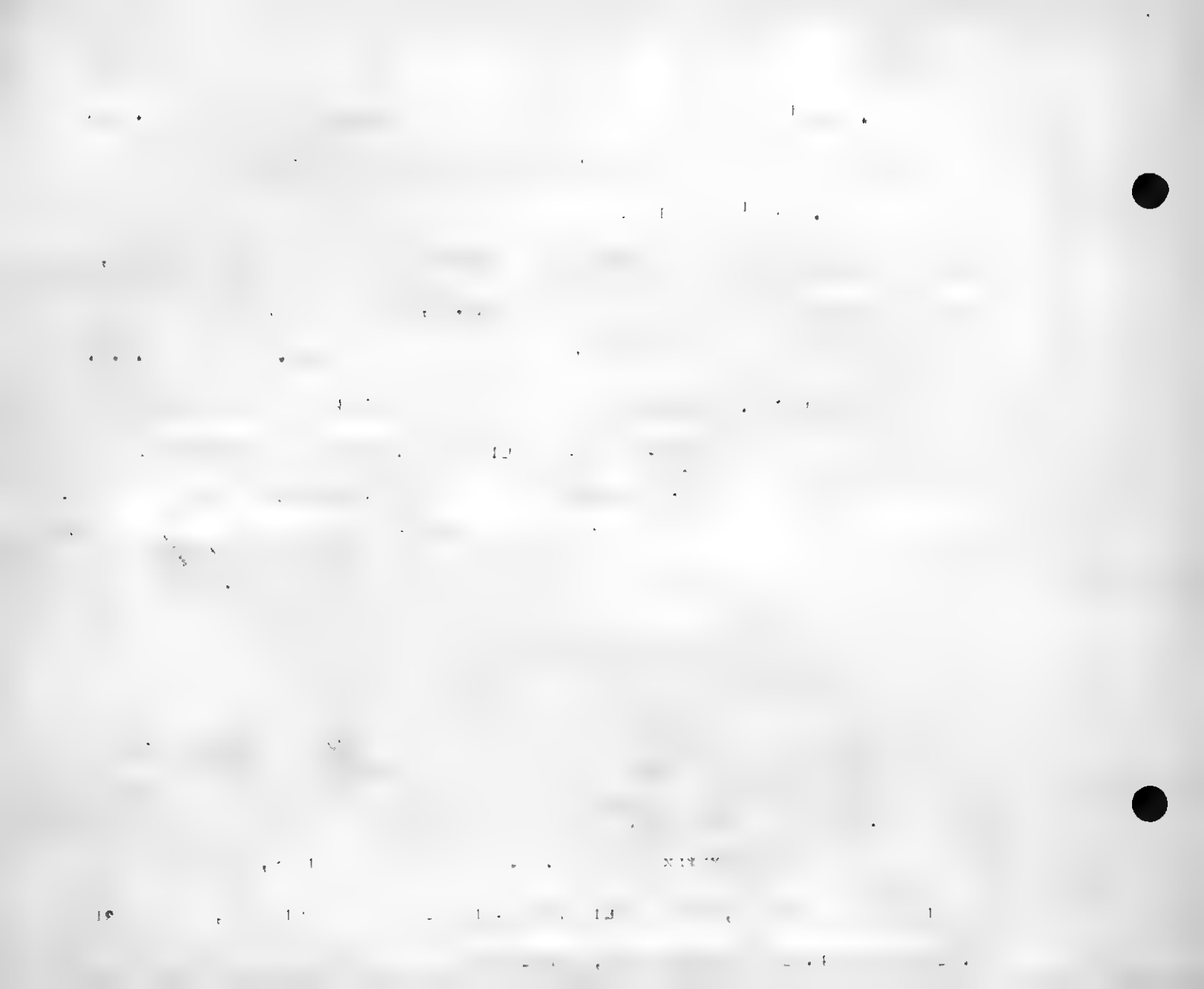
VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|-------------------|-------------------|---|--|---|--|--|------------------------------|---|--|
| 08944 | | | | | | 08934 | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE | | | | | |
| ST. MARY'S MARYLAND | | | | | | MARYLAND ST. MARY'S | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| RURAL DRAYDEN | | | | | | RURAL DRAYDEN | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | | d. STREET ADDRESS | | | | | |
| | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | | 4. DATE OF DEATH | | | Month Day Year | | |
| LEONARD | | | EARL | | | CARNES | | | JUNE 19, 1966 | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| MALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | MAY 20, 1897 | | 69 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| UNDER GROWN FOREMAN | | | | BALTI. GAS & LIGHT | | | | | U.S.A. | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| ANNAIS CARNES | | | | | | ELLA CLARK | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | | | 212-05-5679 | | MRS LOLA H. CARNES | | SAME AS # 2 ABOVE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of prostate</i> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1, 1966, to June 19, 1966, that (I) (we) last saw the deceased alive on June 18, 1966, and that death occurred at 27 M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>P. J. Bean</i> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED June 20/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) P. J. BEAN M. D. | | | | | | 22d. ADDRESS GREAT MILLS, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | | | |
| BURIAL | | JUNE 22, 1966 | | ST. GEORGE EPISCOPAL | | VALLEY LEE, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR JUN 24 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|----------------------------------|---|---|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | c. LENGTH OF STAY IN 1b 26 DAYS | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL LEONARDTOWN | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL | | | | | d. STREET ADDRESS Rt 2 Box 29 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First CHESTER Middle MORTON Last DUNHAM | | | 4. DATE OF DEATH Month JUNE Day 25 Year 1966 | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 21, 1888 | | 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR | | | 10b. KIND OF BUSINESS OR INDUSTRY INSURANCE | | 11. BIRTHPLACE (County & State, or foreign country) MA88. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES A. DUNHAM | | | | | 14. MOTHER'S MAIDEN NAME HATTIE MORTON GODFREY | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WW 1 | | | 16. SOCIAL SECURITY NO. 024-01-1388 | | 17. INFORMANT ELIZABETH DUNHAM | | | Address SAME AS # 2 ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse 177 X DUE TO (b) Carcinomatous DUE TO (c) Noncarcinoma of prostate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/25 , 19 66 , to 6/25 , 19 66 , that (I) last saw the deceased alive on 6/25 , 19 66 , and that death occurred at 9:15 P.M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | | 22b. DATE SIGNED 6/27/66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) JAMES FRANK JARBOE M. D. | | | | | 22d. ADDRESS GREAT MILLS, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF JUNE 29, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL | | 23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | 25a. REC'D BY REGISTRAR JUN 29 1966 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

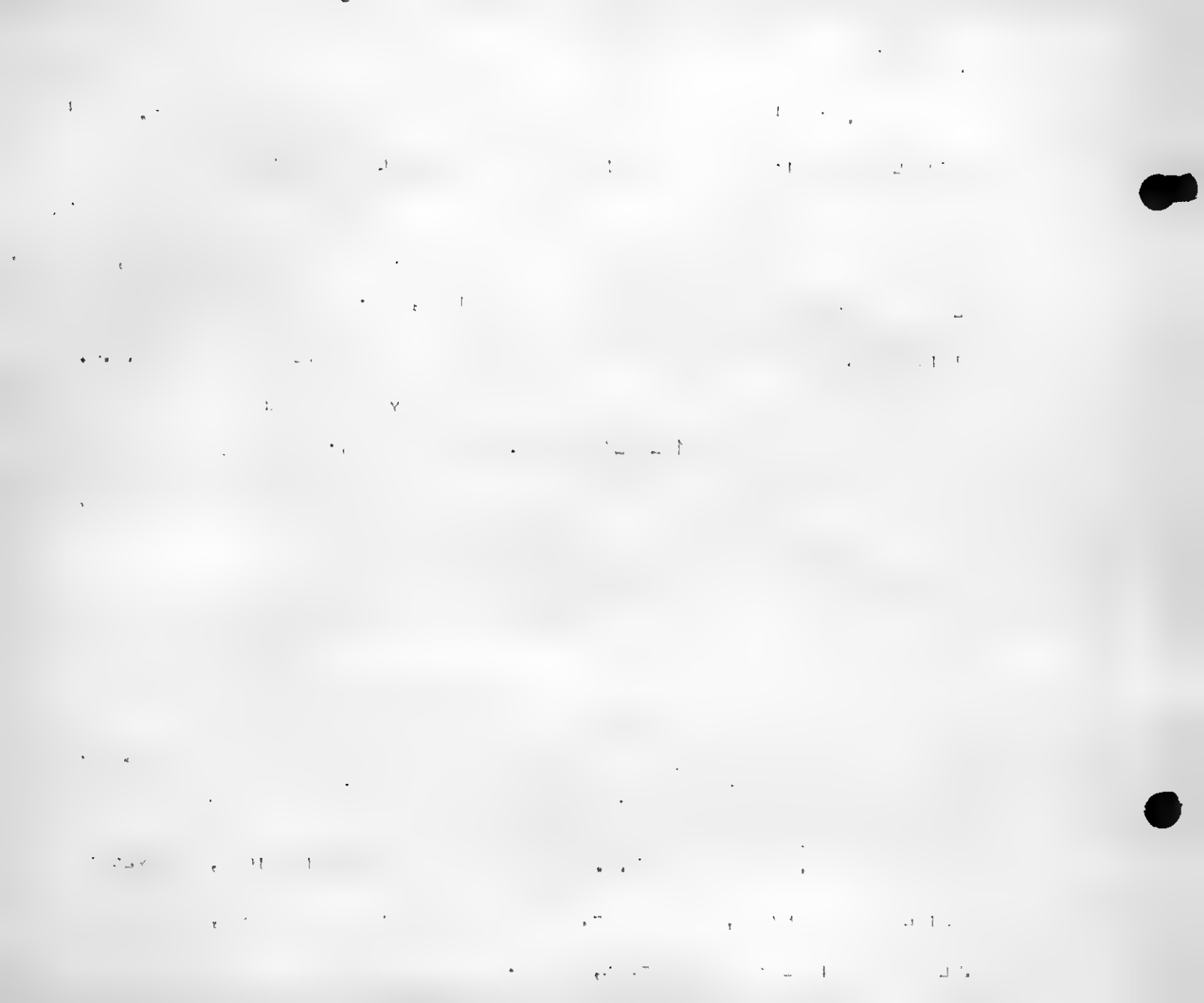


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VR 115 (4)
20M 1/65

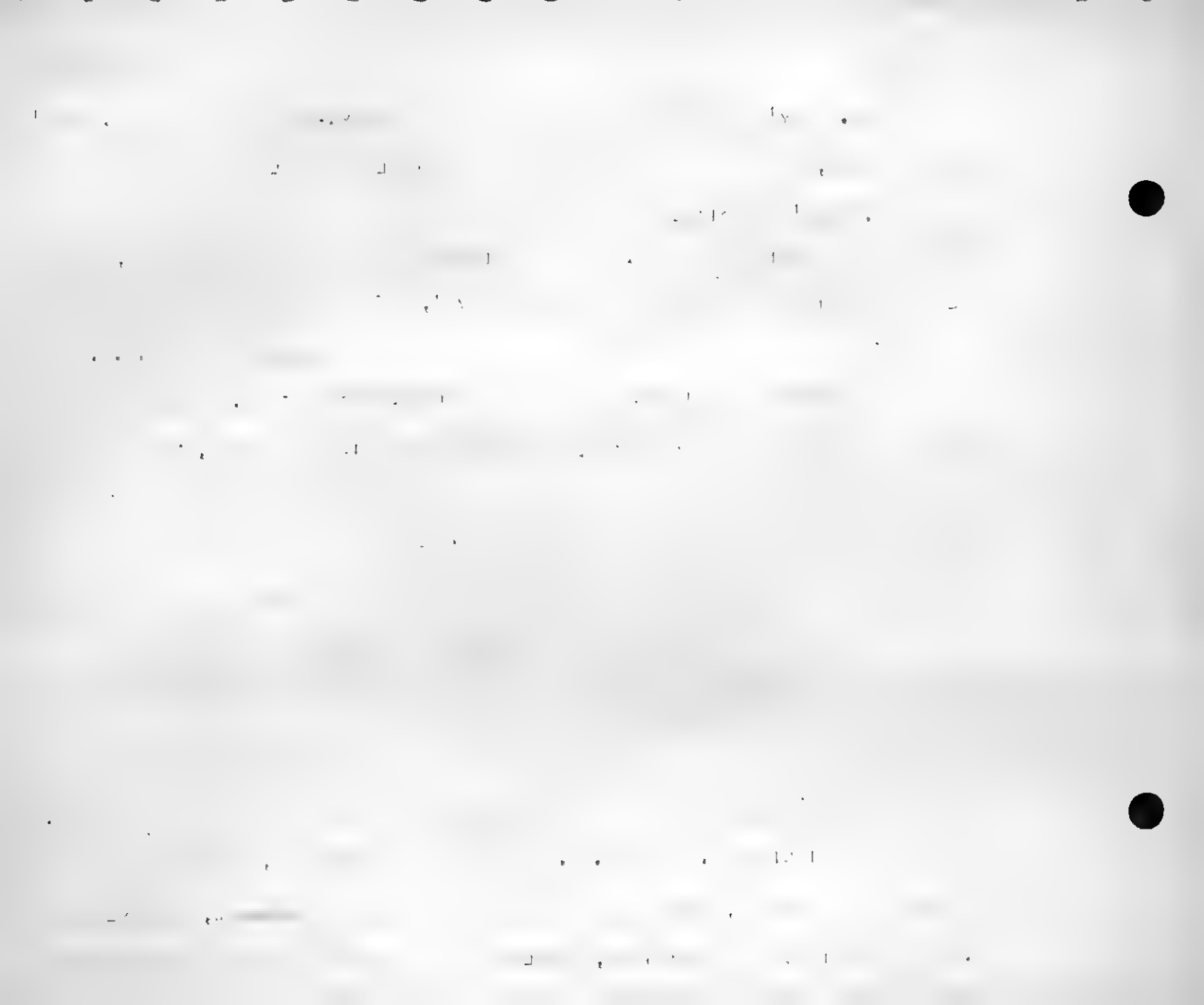
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 08846 08936 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL CHAPTICO | | | c. LENGTH OF STAY IN IB LIFE | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL CHAPTICO 18-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle THURMAN Last FENWICK | | | 4. DATE OF DEATH Month JUNE Day 30 Year 19 66 | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE COLORED | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APRIL 8, 1890 | | 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months 18 Days 1 IF UNDER 24 HRS: Hours 18 Min. 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL SERVICE | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? ? | | | | | 14. MOTHER'S MAIDEN NAME MARY JANE CLARK | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. 219-16-1163 | | 17. INFORMANT MM ALBERTA FENWICK | | | Address SAME AS # 2 ABOVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Pharynx 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 mos | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov , 1965, to June 30 , 1966, that (I) (we) last saw the deceased alive on June 29 , 1966, and that death occurred at 6:40 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Roy Guyther | | | | | 22b. DATE SIGNED | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) W. Roy Guyther M.D. | | | | | 22d. ADDRESS MECHANICSVILLE, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 4, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOSEPHS CEMETERY | | | 23d. LOCATION (City, town or county) (State) MORGANZA, MARYLAND | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | | | | ADDRESS LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR JUL 7 1966 | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|------------------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 08937 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | | | c. LENGTH OF STAY IN 1b 8 DAYS | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MARION Middle G. Last GIBSON | | | | | | 4. DATE OF DEATH Month JUNE Day 15 Year 1966 | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 1, 1893 | | 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JAMES HENRY GIBSON | | | | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXX MARY S. GOODE | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | | 16. SOCIAL SECURITY NO. WW 1 248-38-8608 | | 17. INFORMANT Address ELEANOR ROSE GIBSON ABELL, MARYLAND | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic HD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from April 4, 1966 to June 15, 1966 , that (I) (we) last saw the deceased alive on June 14, 1966 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE W. Clarke Mattingley M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED 6/15/66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M. D. | | | | | | 22d. ADDRESS LEONARDTOWN, MARYLAND | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 18, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY | | | | 23d. LOCATION (City, town or county) (State) BUSHWOOD, MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR JUN 17 1966 | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



CERTIFICATE OF DEATH

08948

08938

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATUXENT RIVER | | | c. LENGTH OF STAY IN 1b 3hr. 50min. | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SECTION HOSPITAL | | | | d. STREET ADDRESS Box 432 Lex. Prk., MD | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Paul First WMN Middle GUVER Last | | | | 4. DATE OF DEATH June 16 19 66 Month Day Year | | | |
| 5. SEX Male | | 6. COLOR OR RACE Cau | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 16, 1966 | |
| 9. AGE (In years last birthday) 3 yrs | | 10. IF UNDER 1 YEAR Months 3 Days 50 | | 11. BIRTHPLACE (County & State, or foreign country) St. Mary's County, MD | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (County & State, or foreign country) St. Mary's County, MD | |
| 13. FATHER'S NAME Jerry W. Guver | | | | 14. MOTHER'S MAIDEN NAME Carolyn Jane Dyson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO none | | 17. INFORMANT Carolyn Jane Dyson same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: 7025 IMMEDIATE CAUSE (a) Cerebral Anoxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Insufficiency DUE TO (c) Prematurity | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 16 Jun , 19 66 , to 16 Jun , 19 66 , that (I) (we) last saw the deceased alive on 16 Jun , 19 66 , and that death occurred at 4:00AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE R. E. Burmeister | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 16 June 1966 | |
| 22c. PHYSICIAN'S NAME (Type) R. E. BURMEISTER LT MC JSN | | | | 22d. ADDRESS Same as #1 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 17, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY | | 23d. LOCATION (City or Town) (County) (State) GREAT MILLS, MARYLAND | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | 25a. REC'D BY REGISTRAR JUN 20 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|----------------------------------|---|---|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 08943 08939 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHAPTICO | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARYS HOSPITAL | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle IRVING Last HARRISON SR. | | | 4. DATE OF DEATH Month JUNE Day 15 Year 19 66 | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JULY 31, 1890 | | 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING - RETIRED | | | | 10b. KIND OF BUSINESS OR INDUSTRY FARM | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME COLUMBUS HARRISON | | | | | 14. MOTHER'S MAIDEN NAME SARAH HIGGS | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | 16. SOCIAL SECURITY NO. 217 36 6944A | | 17. INFORMANT MRS. MARY E. HARRISON - CHAPTICO, MARYLAND | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Obstructive Pulmonary Disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1954 , 19 to June 14 , 19 66 , that (I) (we) last saw the deceased alive on January 14 , 19 66 , and that death occurred at 2 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE John M. Welch | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED 6/16/66 | |
| 22c. PHYSICIAN'S NAME (Type) J. ROY GUYTHER M.D. | | | | | 22d. ADDRESS MECHANICSVILLE, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF 6/17/66 | | 23c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEMETERY | | 23d. LOCATION (City, town or county) (State) CHAPTICO, MARYLAND | | |
| 24a. FUNERAL DIRECTOR John M. Welch | | | | | ADDRESS LEONARDTOWN, MARYLAND | | 25a. REC'D BY REGISTRAR JUN 20 1966 | | |
| | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

88950

CERTIFICATE OF DEATH

08940

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Station Hospital</u> | | d. STREET ADDRESS <u>777B MEMQ</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Agnes King Healy</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1966</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 18, 1932</u> |
| 9. AGE (In years lost birthday) <u>34</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Peter King</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary McGrath</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>055 26 1192</u> | |
| 17. INFORMANT <u>Lawrence M. Healy 777B, MEMQ Patuxent River</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute Asthmatic Attack</u> DUE TO (c) <u>Chronic Bronchial asthma</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 7</u> , 19 <u>66</u> , to <u>June 7</u> , 1966, that (I) (we) last saw the deceased alive on <u>June 7</u> , 19 <u>66</u> , and that death occurred at <u>640AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>F. J. Konicek</u> | | 22b. DATE SIGNED <u>June 7, 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>F. J. Konicek, Lt. MC USN</u> | | 22d. ADDRESS <u>Same as # 1</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT</u> | 23b. DATE THEREOF <u>6/9/66</u> | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) <u>YONKERS NEW YORK</u> |
| 24. FUNERAL DIRECTOR <u>JOHN M. WELCH - LEONARDTOWN, MD.</u> | | 25a. REC'D BY REGISTRAR <u>JUN 13 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

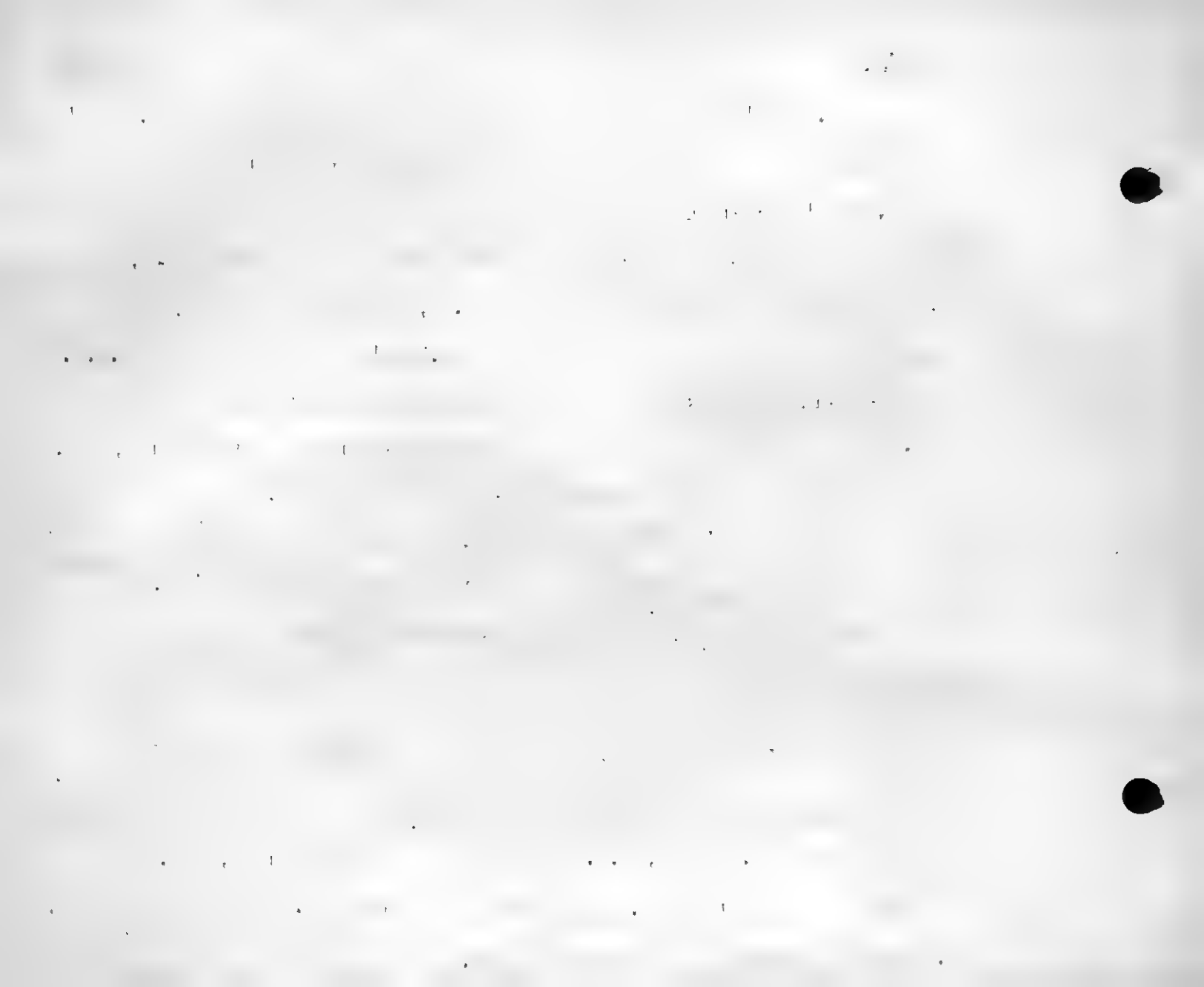
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 08941 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | | | c. LENGTH OF STAY IN 1b 36 DAYS | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First ROSA Middle MAUDE Last HENDERSON | | | | 4. DATE OF DEATH Month JUNE Day 25 Year 19 66 | | | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH FEB. 7, 1894 | | 9. AGE (in years last birthday) 72 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES FRANKLIN CROWDER | | | | | | 14. MOTHER'S MAIDEN NAME ROSE MILBURN | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MAGDALENE LUMPKINS | | Address PINEY POINT, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO Arterio-sclerotic Failure DUE TO Hepatic Failure CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-op Cholecystectomy - Immediate shock | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 15 min | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) this hospital attended the deceased from 6/25/66 to 6/25/66 , that (I) last saw the deceased alive on 6/25/66 , and that death occurred at 7 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE James P. Jarboe | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 6/26/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE, M.D. | | | | | | 22d. ADDRESS GREAT MILLS, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF 6/27/66 | | 23c. NAME OF CEMETERY OR CREMATORY ST. GEORGE ISLAND METHODIST | | 23d. LOCATION (City, town or county) (State) ST. GEORGE ISLAND MD. | | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | | | | | ADDRESS LEONARDTOWN, MD. | | 25a. REC'D BY REGISTRAR JUN 29 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT. **M**

00952

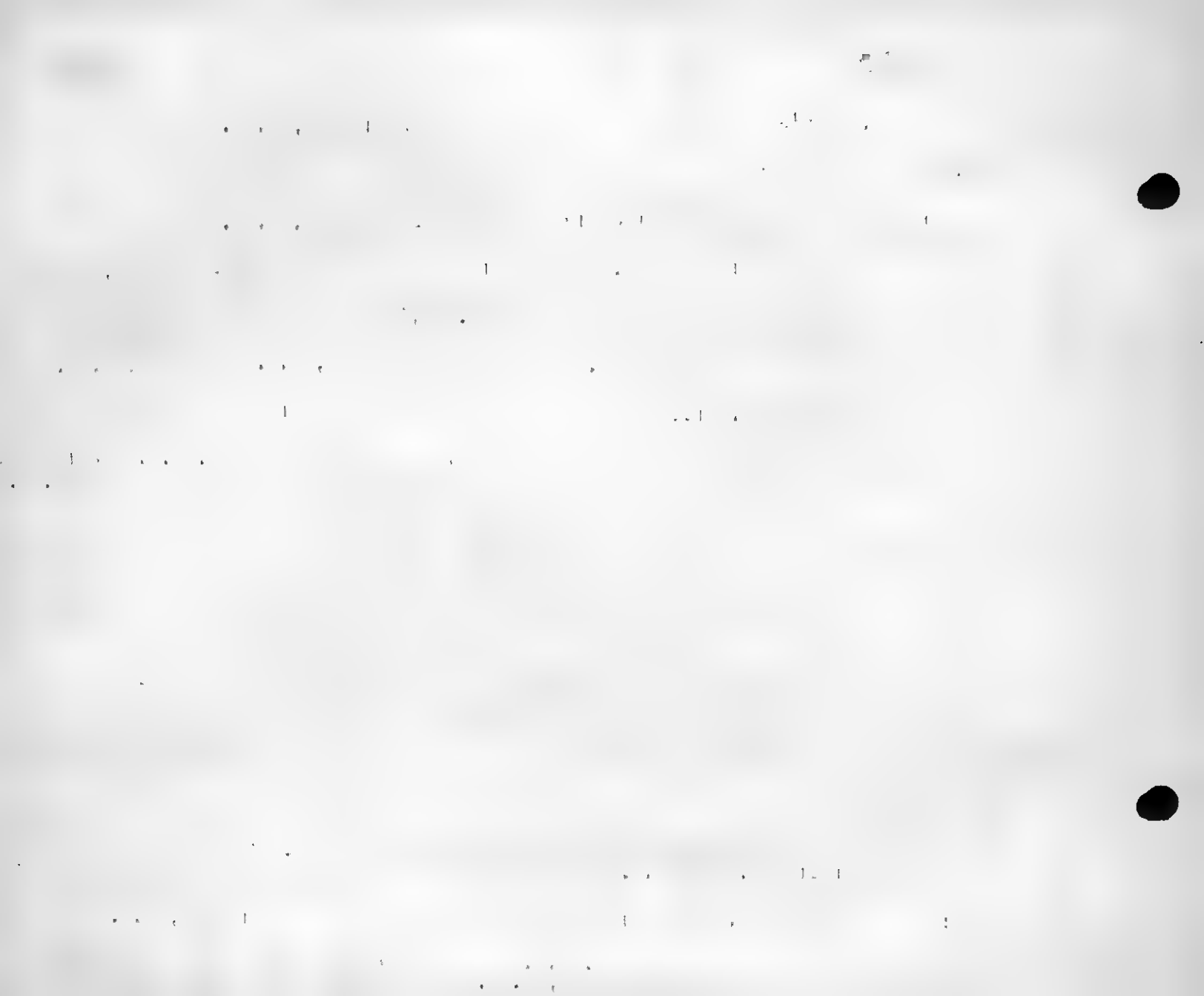
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05942

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

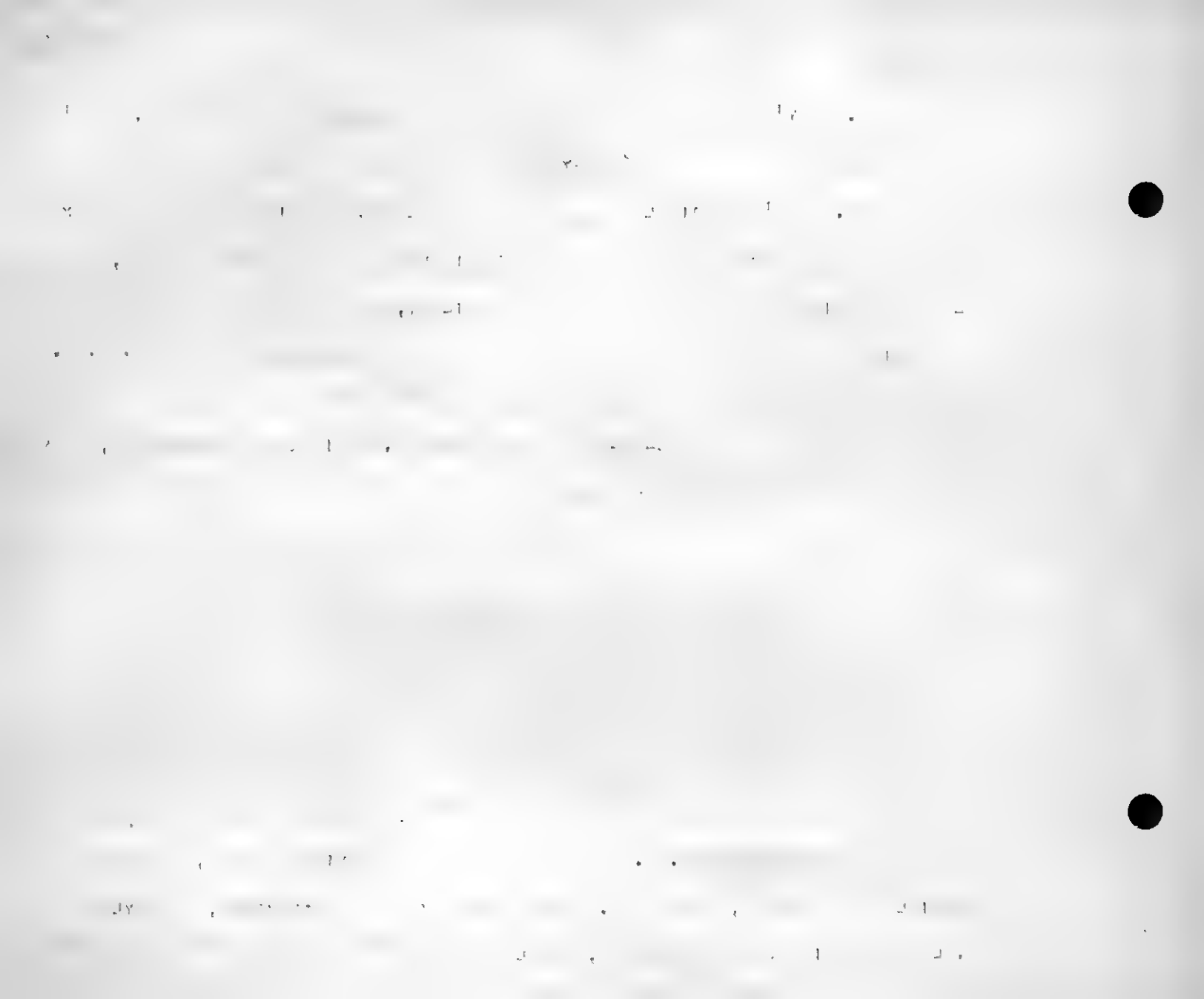
| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE WASHINGTON, D. C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BUSHWOOD RURAL | | c. LENGTH OF STAY IN 1b 3 HRS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MILL CREEK OFF THE WICOMICO RIVER | | d. STREET ADDRESS 328 - 13TH ST. S. E. | |
| 3 NAME OF DECEASED (Type or print) First LOUIS Middle E. Last HILL | | 4 DATE OF DEATH Month JUNE Day 26 Year 19 66 | |
| 5 SEX MALE | 6. COLOR OR RACE NEGRO | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH FEB. 25, 1937 |
| 9. AGE (In years last birthday) yrs 29 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR | |
| 10b. KIND OF BUSINESS OR INDUSTRY MOVING CO. | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME LIVINGSTON H. HILL | |
| 14. MOTHER'S MAIDEN NAME MILDRED WILLIAMS | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT EDNA F. GRAY Address 328 - 13TH ST. S.E. WASHINGTON | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE OR PRIMARY CAUSE OF CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Slipped from a boat in deep water</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6:55</u> p.m. <u>6/26/66</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wicomico River</u> | 20f. (City or town) (County) (State) <u>Bushwood St. Marys Md</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>William D. Boyd</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED <u>6/27/66</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF JUNE 29, 1966 | 23c. NAME OF CEMETERY OR CREMATORY LINCOLN CEMETERY | 23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C. |
| 24. FUNERAL DIRECTOR MATTHEWS & BARNES Address 3619 - 148th St. N.W. Washington, D. C. | | 25a. REC'D BY REGISTRAR DATE JUN 29 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | | | c. LENGTH OF STAY IN 1b 11 DAYS | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL | | | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle LEO Last MATTINGLEY | | | | | | 4. DATE OF DEATH Month JUNE Day 4 Year 1966 | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH APRIL 27, 1878 | | 9. AGE (in years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME LEO MATTINGLEY | | | | | | 14. MOTHER'S MAIDEN NAME MARY KNOTT | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 220-40-5660 | | 17. INFORMANT MRS GRACE M. MATTINGLEY | | Address LEONARDTOWN, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 44-66 DUE TO (b) Arteriosclerosis DUE TO (c) Arteriosclerosis | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5-7 days 5-7 yrs. 30 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Lung & Hemorrhage | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 to 4 June , 19 66 , that (I) was last saw the deceased alive on 4 June , 19 66 , and that death occurred at 9 M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Ernest D. Rehm | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 6 June 1966 | | | |
| 22c. PHYSICIAN'S NAME (Type) ERNEST REHM M. D. | | | | | | 22d. ADDRESS LEXINGTON PARK, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 7, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY | | | | 23d. LOCATION (City, town or county) (State) HOLLYWOOD, MARYLAND | | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | | | | | 25a. REC'D BY REGISTRAR JUN 9 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



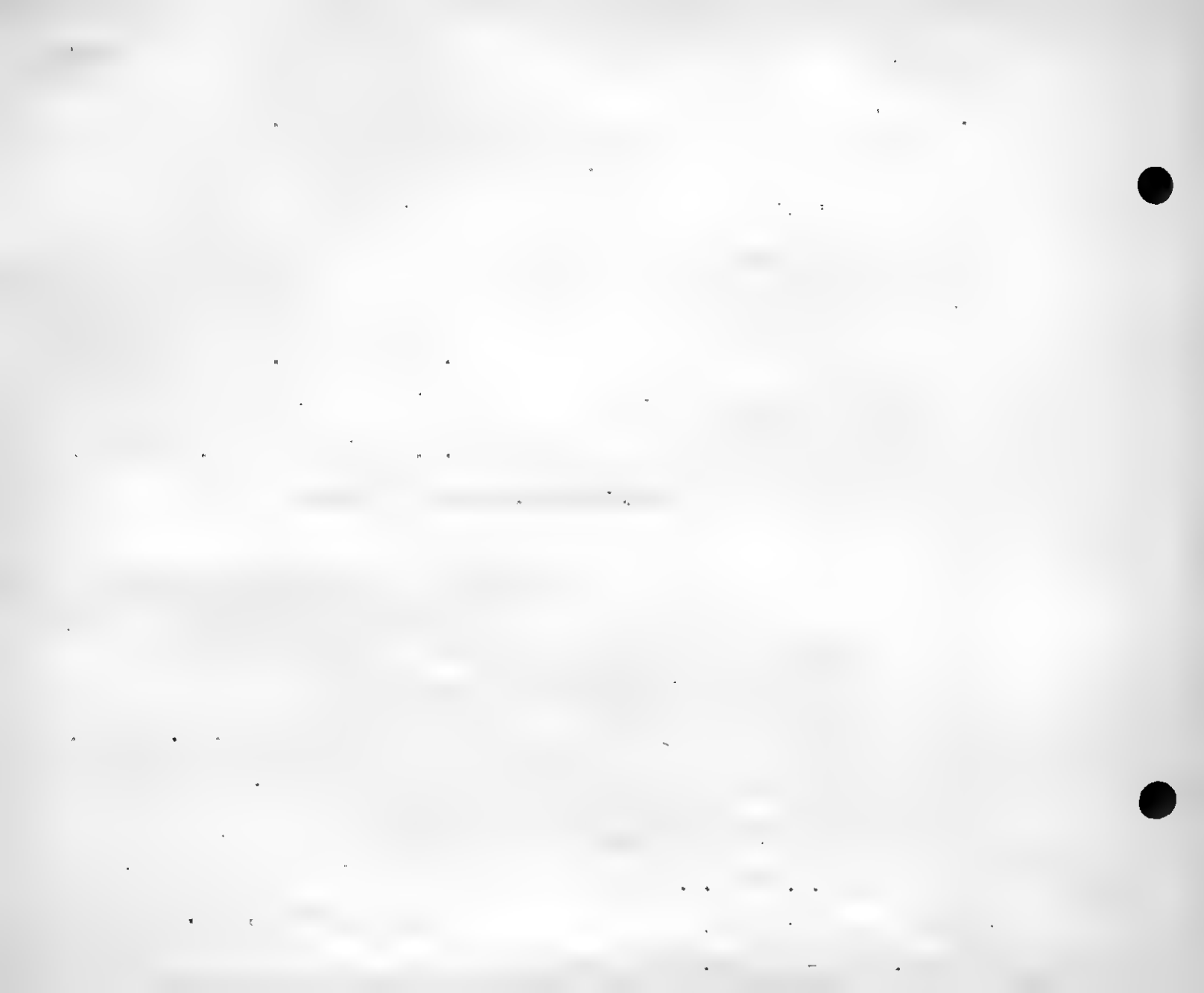
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

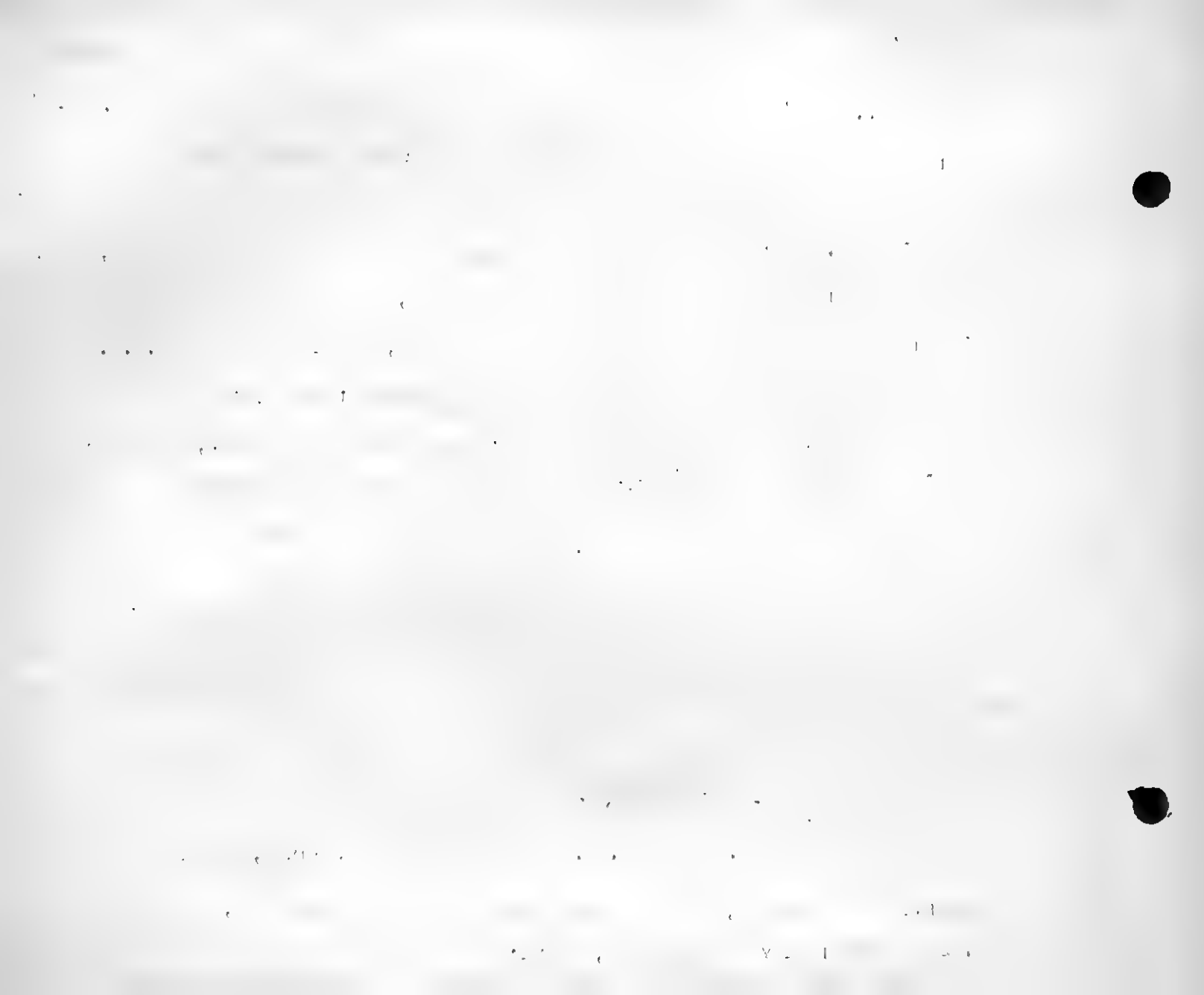
| <div>Item 18 Film G378 7/20/66</div> <div>00054</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>08944</div> | | | | | | | | | |
|--|-------------------------|---|---|-------------------------------|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Patuxent River c. LENGTH OF STAY IN RURAL 5 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Station Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Scotland d. STREET ADDRESS Box #11 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Robert Andrew Neckel | | | | | 4. DATE OF DEATH Month Day Year June 29 1966 | | | | |
| 5. SEX Male | 6. COLOR OR RACE Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 17 Feb 66 | | 9. AGE (In years last birthday) yrs. 4 Months 12 Days Hours Min. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St. Mary's, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME John Charles Thomas Neckel | | | | | 14. MOTHER'S MAIDEN NAME Judith Ann Knowles | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT John C.T. Neckel Box#11, Scotland, Md. Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. ... pending autopsy 4681 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Interstitial pneumonitis DUE TO (c) Mesenteric adenitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Left unattended in car. on hot day. | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year unk a.m. 29 June 1966 p.m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Scotland, St. Mary's, Md. | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE C. F. MAC CARTHY | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22. DATE SIGNED 29 June 1966 | | | |
| EXAMINER'S NAME (Type) C. F. MAC CARTHY LT MC USN Same as #1 | | | Address (Street, city, town, or county) | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT | | | 23b. DATE THEREOF 7/1/66 | | 23c. NAME OF CEMETERY OR CREMATORY DETROIT, MICH. | | 23d. LOCATION (City, town or county) (State) | | |
| 24. FUNERAL DIRECTOR JOHN M. WELCH | | | ADDRESS LEONARDTOWN, MARYLAND | | | 25a. REC'D BY REGISTRAR JUL 6 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 08955 08945 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGE | | | | c. LENGTH OF STAY IN ID 5 YEARS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ANNAPOLIS HURRY 12-1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RIDGELL REST HOME | | | | | | d. STREET ADDRESS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last J. BURGE BRUCE QUADE | | | | | | 4. DATE OF DEATH Month Day Year JUNE 23, 19 66 | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MARCH 18, 1887 | | 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) HURRY, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME JOHN JOSEPH QUADE | | | | | | 14. MOTHER'S MAIDEN NAME MARY WASHINGTON LACEY | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW1 | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address MRS LOUIS THOMPSON AVENUE, MARYLAND | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Thrombosis 4201 DUE TO (b) Cornary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tbc. far advanced, arrested | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/23, 19 66 to 6/23, 19 66 that (I) (we) last saw the deceased alive on 6/23, 19 66 and that death occurred at 1 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE James P. Jarboe M.D. | | | | | | 22b. DATE SIGNED 6/24/66 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M. D. | | | | | | 22d. ADDRESS GREAT MILLS, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF JUNE 25, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY | | | 23d. LOCATION (City, town or county) (State) BUSHWOOD, MARYLAND | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR JUN 29 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

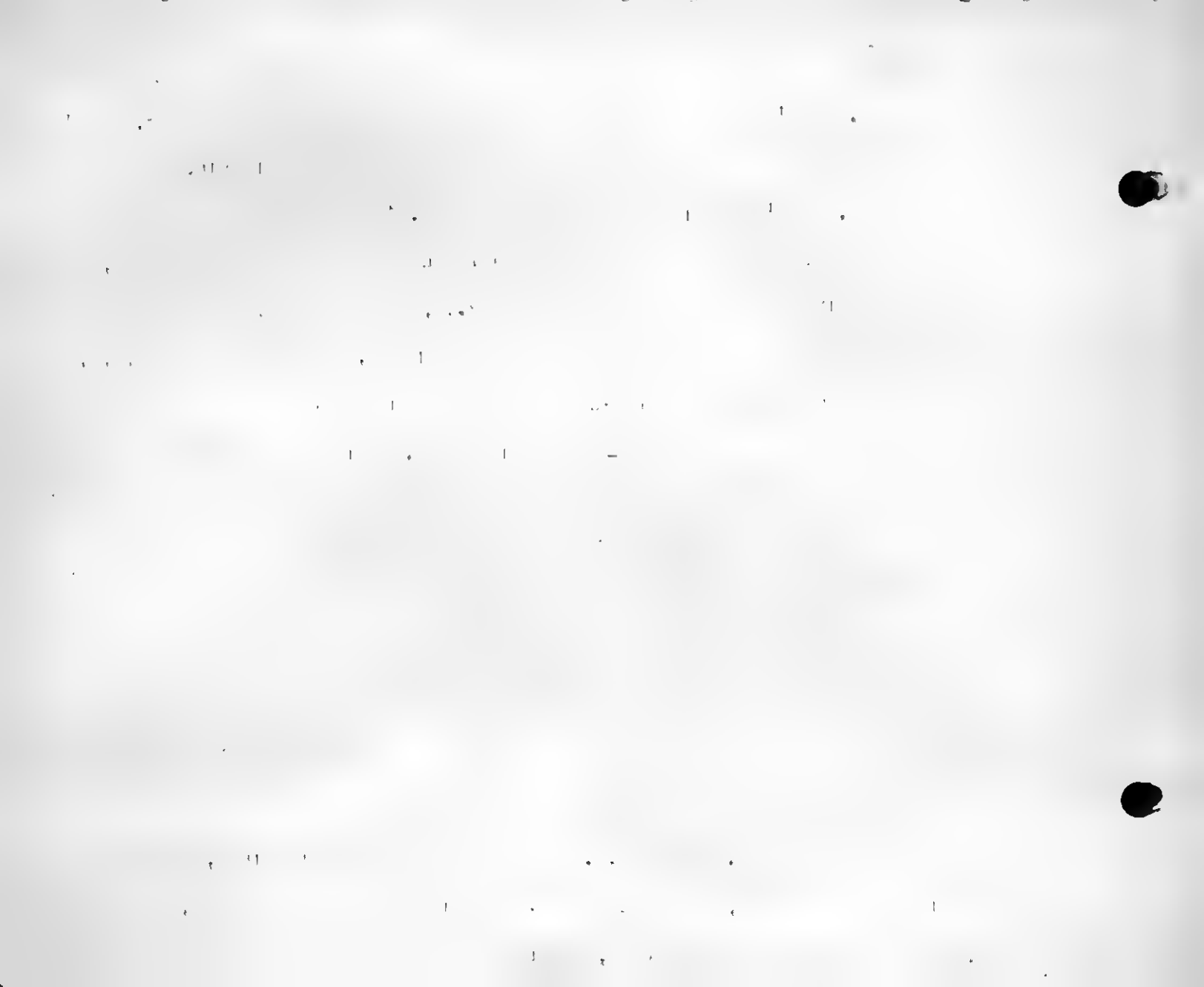


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00056
08948
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL MECHANICSVILLE d. STREET ADDRESS Rt. 1 Box 273 A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) WOODROW EDGAR SPRINKEL | | 4. DATE OF DEATH Month JUNE Day 24 Year 1966 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 17, 1914 |
| 9. AGE (In years last birthday) 51 yrs. | | 10. IF FUNER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR | | 10b. KIND OF BUSINESS OR INDUSTRY TRANSPORT | |
| 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME SAMUEL SYLVESTER SPRINKEL | | 14. MOTHER'S MAIDEN NAME MATTIE BOND | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-03-0087 | |
| 17. INFORMANT MILDRED G. SPRINKEL | | Address SAME AS # 2 ABOVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordic standstill DUE TO (b) Diffuse carcinoma testis DUE TO (c) Cancer colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 20 hrs 2 yrs Yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to June 24 , 19 66 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Lewon B. Beurbe | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) LEWON B. BEURBE M.D. | | 22d. ADDRESS MECHANICSVILLE, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF JUNE 27, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEMORIAL PARK | | 23d. LOCATION (City, town or county) (State) GLEN BERNIE, MARYLAND | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY | | 25a. REC'D BY REGISTRAR LEONARDTOWN, MARYLAND | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JUN 27 1966 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 08957 | | | | | | | | | | | |
| 08949 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARYS MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARYS | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - CALIFORNIA | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARYS HOSPITAL | | | | | | d. STREET ADDRESS 18-1 | | | | | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle GEORGE Last STRICKLAND | | | | | | 4. DATE OF DEATH Month JUNE Day 23 Year 1966 | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH AUG. 31, 1896 | | 9. AGE (In years last birthday) 69 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING (RETIRED) | | | | 10b. KIND OF BUSINESS OR INDUSTRY FARM | | 11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CYRUS M. STRICKLAND | | | | | | 14. MOTHER'S MAIDEN NAME HELEN FRANCES TAYLOR | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 214 14 8203 | | 17. INFORMANT Address MRS. ROSA H. STRICKLAND SAME AS # 2 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 1939 DUE TO (b) Glio Blastoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Ischemia and Coronary Insufficiency | | | | | | | | | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH Several months | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 8 , 1966, to June 22 , 1966, that (I) (we) last saw the deceased alive on June 22 , 1966, and that death occurred at 12:20 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Robert T. Fuchs | | | | | | 22b. DATE SIGNED 6/24/66 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) ROBERT FUCHS M.D. | | | | | | 22d. ADDRESS LEONARDTOWN, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF 6/25/66 | | 23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY | | 23d. LOCATION (City, town or county) (State) GREAT MILLS, MARYLAND | | | |
| 24. FUNERAL DIRECTOR JOHN M. WELCH - LEONARDTOWN, MARYLAND | | | | | | 25a. REC'D BY REGISTRAR June 27 1966 | | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or removal, and interment, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|----------------------------------|---|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN | | | | c. LENGTH OF STAY IN 1b 2 WEEKS | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S NURSING HOME | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle MARTIN Last WIBLE | | | | | 4. DATE OF DEATH Month JUNE Day 5 Year 1966 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH OCT. 25, 1880 | | 9. AGE (In years last birthday) 85 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) HOLLYWOOD, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH C. WILLE | | | | | 14. MOTHER'S MAIDEN NAME MARTHA MATHEWS | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. 220-34-2936 | | 17. INFORMANT Address MRS ELLA N. WIBLE HOLLYWOOD, MARYLAND | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection 332X DUE TO (b) Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cerebral arteriosclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH weeks years many years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct , 19 67 , to June , 19 66 , that (I) (we) last saw the deceased alive on June 4 , 19 66 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE David L. Mossman | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 6/6/66 | | |
| 22c. PHYSICIAN'S NAME (Type) DAVID L. MOSSMAN M. D. | | | | | 22d. ADDRESS MECHANICSVILLE, MARYLAND | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF JUNE 8, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS | | 23d. LOCATION (City, town or county) (State) HOLLYWOOD, MARYLAND | | |
| 24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND | | | | | 25a. REC'D BY REGISTRAR JUN 7 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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DAVID L. ROSEMAN M. D.

ROSEMAN M. D.

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